United States Senate
WASHINGTON, DC 20510

January 31, 2022

The Honorable Lloyd J. Austin III
Secretary
Department of Defense
1000 Defense Pentagon
Washington, DC 20301-1000

The Honorable Denis R. McDonough
Secretary
Department of Veterans Affairs
810 Vermont Ave NW
Washington, DC 20571

Dear Secretary Austin and Secretary McDonough:

We write to express our/my disappointment following the release of the U.S. Department of Defense's (DoD) Office of Inspector General (OIG) report titled *Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members* (DODIG-2022-030). The report highlighted DoD's failure to take steps to screen for and prevent suicide amongst servicemembers during the transition period from DoD to the Department of Veterans Affairs (VA).

The report required by Presidential Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, highlighted multiple DoD failures during the transition process for all servicemembers with planned or pending separation from military service. The DoD OIG found that DoD did not screen for suicide risk or provide uninterrupted mental health care to transitioning servicemembers as required by Federal and DoD guidance. Specifically, DoD did not establish and implement oversight of the Mental Health Assessment (MHA) and lacked proper suicide risk screening procedures for transitioning servicemembers. DoD failed to provide continuity of mental health care by an insufficient definition of a warm handoff between the Departments, deficient provider training protocols, lack of standardized documentation methods, and unsatisfactory oversight procedures to ensure compliance of DoD Instruction (DoDI) 6490.10, *Continuity of Behavioral Health Care for Transferring and Transitioning Service Members*.

The report highlighted that the Defense Health Agency (DHA) and military services did not prioritize the MHA as part of the Separation History and Physical Exam (SHPE). Additionally, DoD and the services relied on expired policy to govern suicide risk screening and referral

processes.[1] DoD did not implement a "warm handoff approach," as required by DoDI 6490.10, to create continuous mental health care during the transition from the MHS to the Veterans Health Administration (VHA).[2]

We know that the first-year post separation is critical for servicemembers, veterans, and their families. These suicide prevention screening deficiencies could affect patient care at an important point in a veteran's life. DoD and VA must do more to continue assisting servicemembers as they transition from uniform to civilian life. We strongly support the report's recommendations, and urge your Departments to fully implement them in order to enhance the transition from military service and save lives. The report recommends that the Assistant Secretary of Defense for Health Affairs, in coordination with the DHA Director, and the Surgeon General of each Armed Service, establish consistent policies and procedures to manage suicide risk screening and referrals as part of the medical process for transitioning servicemembers.

The report also recommends that the DHA Director, in collaboration with the Director of the DoD and Veterans Affairs Collaboration Office, identify gaps in continuous mental health care for servicemembers who are transitioning from the Military Health System to the Veteran Health Administration, and ensure servicemembers have continuous healthcare for the duration of their transition. I/We further ask to provide support, time, and budget resources to initiatives intended to improve the quality of the warm handoff of care.[3]

We respectfully request answers to the following questions by January 30, 2022, and stand ready to work with you to combat servicemember and veteran suicide.

- What steps are DoD and VA taking to ensure that all of the recommendations in the Evaluation of the Department of Defense's Implementation of Suicide Prevention Resources for Transitioning Uniformed Service Members (DODIG-2022-030) are implemented?
- What actions are DoD and VA taking to establish consistent policies and procedures to manage suicide risk screening and referrals as part of the medical process for transitioning servicemembers? When do you expect to have the policies and procedures in place?
- Where are the gaps in continuous mental health care and what is DoD and VA doing to ensure that these gaps are fixed?
- The report stated that there are no clear guidelines exist to help inform what dictates a warm handoff and there was no warm handoff from DoD to VA. What is DoD and VA doing together to establish what a warm handoff is and ensure a warm handoff takes place?

[1] https://www.dodig.mil/reports.html/Article/2841764/evaluation-of-the-department-of-defenses-implementation-of-suicide-prevention-r/

[2] https://www.dodig.mil/reports.html/Article/2841764/evaluation-of-the-department-of-defenses-implementation-of-suicide-prevention-r/

[3] https://www.dodig.mil/reports.html/Article/2841764/evaluation-of-the-department-of-defenses-implementation-of-suicide-prevention-r/

We appreciate your service, and ask that you keep us informed as you develop and execute the policies and procedures that will help save lives during the transition process. Thank you for your time and attention to this important matter.

Sincerely,

Sherrod Brown
United States Senator

Richard Blumenthal
United States Senator

Margaret Wood Hassan
United States Senator

Mazie K. Hirono
United States Senator

Patty Murray
United States Senator

Bernard Sanders
United States Senator